

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER:

**02-02**

2. STATE  
**NC**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE  
SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

**January 1, 2002**

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

**42 CFR 440.20**

7. FEDERAL BUDGET IMPACT:

**\$0**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

**Attachment 3.1-A.1, Page 5**

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

**Attachment 3.1-A.1, Page 5**

10. SUBJECT OF AMENDMENT:

**Prior approval process for psychiatric outpatient visits for recipients 21 years and over**

11. GOVERNOR'S REVIEW (Check One):

- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT  
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED: Not Required

12. SIGNATURE OF STATE AGENCY OFFICIAL:

*Carmen Hooker Buell*

13. TYPED NAME:

**Carmen Hooker Buell**

14. TITLE:

**Secretary**

15. DATE SUBMITTED:

**December 18, 2001**

16. RETURN TO:

Office of the Secretary  
Department of Health and Human Services  
2001 Mail Service Center  
Raleigh, North Carolina 27699-2001

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED:

**December 27, 2001**

18. DATE APPROVED:

**March 21, 2002**

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVED MATERIAL:

**January 1, 2002**

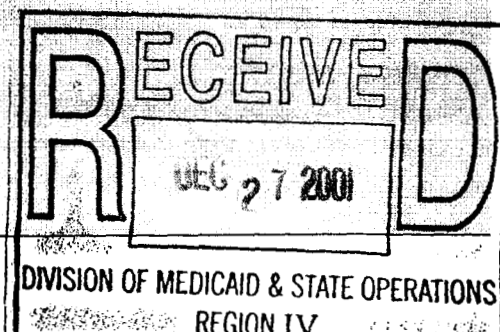
20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

**Eugene A. Grasser**

22. TITLE: **Associate Regional Administrator  
Division of Medicaid and State Operations**

23. REMARKS:



Level of Care criteria for ventilator-dependent care is described in Appendix 4 of Attachment 3.1-A.

2.a. Outpatient Hospital Services

All medical services performed must be medically necessary and may not be experimental in nature. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants.

- (1) Prior approval shall be required for each psychiatric outpatient visit after the eighth visit for recipients 21 years and over. The twenty-four (24) visit limitation per year does not apply to recipients 21 years and over receiving mental health services subject to utilization review. Approval will be based on medical necessity.
- (2) Prior approval shall be required for each psychiatric hospital outpatient visit after the 26<sup>th</sup> visit for recipients under age 21.
- (3) Routine physical examinations and immunizations are covered under Adult Health Screening and under Early Periodic Screening Diagnosis and Treatment (EPSDT).
- (4) "Take home drugs", medical supplies, equipment and appliances are not covered, except for small quantities of medical supplies, legend drugs or insulin needed by the patient until such time as the patient can obtain a continuing supply.

TN No. 02-02  
Supersedes  
TN No. 00-12

Approval Date MAR 21 2002 Eff. Date 01/01/02